Public Sector Ban on Employment – Issues and Recommendations

Summary

As of 2014, a decision banning the employment of new workers in the public sector has been in force in the Republic of Serbia. Permits/approvals for new employment are administered through the Commission of the Government of the Republic. The reason for the introduction of the Law was to reduce public sector expenditures. There are no systematic, reasoned and reliable reports on the effects of the public sector employment ban. There is no confirmed information on whether or not there have been any positive effects of said decision (increased work efficiency, reduction in redundancies and/or unnecessary staff, an improved employee qualification structure, reduction in the share of administrative posts versus professional, etc.) or the negative effects of this decision (reduction of quality and availability of public services, reduction of the number of professional posts, arbitrary decision-making on the abolition of posts, disproportionate reduction of the number of posts available in certain sectors, etc.). Partial data indicate that this Decision has had a particular effect on those sectors which entitle direct communication with the public and meeting the needs of the citizenry - health, education, public utilities and others.

In healthcare protection, numerous negative effects are evident[1]. The focus of this text is on the **spatial availability of primary and preventative** healthcare provided to the citizens of Serbia.

The following issues are at the forefront:

A large number of inhabitants per physician. Even prior to the ban on public sector employment, Serbia's ratio of inhabitants per physician was significantly unfavourable (346 in./phy.) in comparison to the EU average (267 in./phy., 2017). At the end of the 1990s, the number of inhabitants per physician in Serbia stood at 401 (data from 1998). In just over a decade, this ratio has **significantly improved so that in 2013, it stood at 339 inhabitants per physician.** Since the decision to ban public sector employment was rendered, **the number of inhabitants per physician has increased:** in 2017, it increased to **351** and in 2019, to 349. For the most part, this is a consequence of the reduced number of physicians employed in the public sector. In the period 2011 – 2017 **the number of physicians employed in the public sector was reduced by 5.0% (**General Practicioners (GPs) by 18.2%, specialists and those completing their residency by 2.5%). In this same period, the number of dentists was reduced by more than a quarter. When considered by region, the decrease in the number of physicians is extremely uneven with Southern and Eastern Serbia being hardest hit, as these regions have the weakest development indicators. According to research conduced by *Nova ekonomija,* on the basis of data collected by the Dr Milan Jovanović Batut Institute and the Fiscal Council, over the past five years, the number of healthcare workers has been reduced by as many as 10,000 people. (…) there are almost 1,000 fewer MDs, and administrative and techncial staff have been reduced by approximately five thousand people". (novaekonomija-rs/vesti-iz-zemlje/povećanje-plata-produžilo-zabranu-zapošljavanja-u-državi/) (11.11.2019). The same article provides assessments of the president of the Serbian Trade Union

[1] The analysis that follows does not include the issues which have arisedn during the corona virus pandemic.

of Doctors and Pharmacists who said that "the healthcare system is currently lacking between 3,500 and 4,000 physicians and approximately 8,000 nurses and technicians, while this same sector has a (roughly) 15 percent surplus of non-medical staff". These numbers represent the number of public healthcare workers and the assessed need for medical services with which Serbia greeted the COVID-19 pandemic. It should be added that the increase in the number of inhabitants per physician occurred at the same time that Serbia recorded a continuous decrease in the number of inhabitants (due to negative natural growth and emigration to other countries) as well as when in 2015, in the category of staff (physicians and medical staff) employed outside of an employment relationship, i.e. temporary and periodical employees and those working under a purchase order contract, were also counted, and even this change in the way the number of medical staff was recorded did not improve the ratio of inhabitants per physician. In addition to the evident deficiency in the number of physicians per inhabitants, **the implementation of the employment ban was more intense in the healthcare and social care sectors in comparison to government administration, defense and compulsory insurance.**

The above data relate only to physicians employed in the public sector, not on physicians and dentistry staff who work solely in the private sector. The reason for this is not only the lack of available data on physicians and dentists employed in the private sector, but rather, and more importantly, that these sectors are not interconnected/tied to each other. Compulsory healthcare and social insurance provided to the population does not cover private sector services (the use of healthcare identification, voucher system, etc.), rather, these services are charged in the same way as any other service provided on the market. In other words, **private healthcare is not an integral part of the public healthcare protection system** within the Republic of Serbia. For this reason, the inclusion of private sector data would only obscure the realistic state of the availably of healthcare services, primarily because these services are too expensive for most of Serbia's inhabitants to afford. Furthermore, the private healthcare sector is concentrated in (larger) towns and cities i.e., there is very little chance that private sector healthcare will be organised in rural communities, in particular, difficult to reach and isolated areas, with high consentrations of desolate, elderly households.

There are large differences among municipalities in terms of the inhabitants per physician indicator. Available sources do not allow for the separate categorisation of physicians employed in healthcare centres from those employed in hospitals, clinical centres and other specialised healthcare institutions. Municipalities in which the number of inhabitants per physician is above average are, as a rule, municipalities that have only healthcare centres and no other type of healthcare institution. In other words, these are municipalities with a large share of rural inhabitants and larger numbers of rural communities whose inhabitants are not only deprived of healthcare services within their communities themselves (with the exception of rual clinics that can, for the most part, provide only rudamentary healthcare services), but have little access to healthcare services in the municipal centre due to numerous restrictions (administrative, difficult to maintain and unmaintained local roads, expensive and irregular public transport, if any, etc.). In 56.3% of Serbia's municipalities (not including Belgrade's municipalities, where in a number of these, the ratio has deterriroated), the number of inhabitants per physician in the observed period has increased. In 42.8% (2017) of 152 municipalities (to which the provided data refers), the number

of inhabitans per physician is double the average in Serbia (more than 702 inhabitants per physician). In 13 municipalities, the number of inhabitants per physician was over a thousand. These data show markedly uneven spatial distribution and availability of GPs, who are key players in preventive and primary healthcare. In addition, the fact that over half of the share of municipalities in which the number of inhabitants per physician is twice as high as the national average indicate low availability of medical services, especially for a large number of inhabitants in rural communities located far from municipal centres, where healthcare centres are located. We again emphasise that **those living in rural communities, with poor connections and poor local roads to municipal centres, are particularly endangered and deprived of medical care.** These people are deprived of preventive, primary and specialised healthcare.

In the EU accession process, it is necessary to highlight that the basic **commitments of the EU in the area of public healthcare are**: improvement of the public healthcare sector, availability of preventive healthcare services, a community-based primary care system, equality and fairness in access to healthcare services, reduced healthcare inequalities, harmonising the development of healthcare services to the needs of the population.

Serbia is characterised by a relatively high share of healthcare spending. Referring to data collected by the World Bank (for 2016), M. Gajić claims that the level of spending on healthcare (in relation to the GDP) is significantly higher in Serbia, in comparison to surrounding countries. This author also refers to Eurostat data that only a few countries in the EU had higher healthcare spending (relative to GDP) than Serbia (Great Britain, Germany, Austria, the Netherlands, Belgium, Sweden, Finland and France). (*How much does Serbia spend on healthcare compared to other countries?*) (talas.rs/2020/04/09/koliko-srbija-troši-na-zdravstvo-u poređenju-sa-drugim-zemljama/). The author further says: "The difference between Serbia (and which is evident also in Bulgaria) and the other countries listed is in the high share of private costs. (…) Bearing in mind that Serbia's system of voluntary health insurance is rudimentary, almost all of these costs are actually household costs. (…) This indicates that the situation in our country's public healthcare system is unfavourable: people do not have access to adequate services from public sector physicians, so they seek treatment privately. However, this option is not available to everyone, rather only to those who can afford it. (…) Government insurance costs in Serbia, looking at both expenditures financed through compulsory health insurance and those through the general tax system, are somewhere at the level of the average of similar economies. (…) Apparently, we cannot say that not enough funds are invested in our healthcare system, in international comparison. But it seems that one of the main illnesses plaguing our society - the lack of efficient public institutions resulting from nepotism, corruption, political rigging and poor governance - has successfully infultrated our healthcare system as well. In the text, *Chronic Diseases of Serbian Healthcare* (novaekonomija.rs/arhiva-izdanja/broj-48-mart-2018/hronične-bolesti-srpskog-zdravstva) we find the following claims: "With almost ten percent of Serbia's GDP, the amount that goes to healthcare, the country is on average with the European Union and at the top in the region. (…) However, although Serbia does not lag behind in terms of healthcare spending, in fact, it is a regional leader, both relatively and absolutely, the situation in Serbia's healthcare was assessed as critical last year in a study published in the London-based magazine Economist. The main causes of this situation are (…) a high level of corruption in healthcare and

ubiquitous informal payments for healthcare services. (…) According to the World Bank, **almost 40 percent of healthcare spending comes out of the pockets of citizens**, which is an extremely high share of private payments, making Serbia one of the poorest countries in the world. At the same time, such parameters negatively affect the equal access of all citizens to healthcare services. The remaining 60 percent of healthcare costs are financed from the National Health Insurance Fund (NHIF), which is also paid for by the people, through compulsory healthcare insurance contributions, with a (smaller) portion coming from the state budget. (…) it is practically an impossibility for an outsider to find out where the population's money ends up, how this money is distributed, nor has a single detailed cost analysis on Serbia's healthcare financing spending model been performed. (…) Two huge issues in Serbia's healthcare system are diversity in the quality and availability of healthcare services within the entire country's territory, in particular, these differences are pronounced when comparing smaller settlements and larger towns/cities, which has led to a situation where all those who can, come to Belgrade for treatment, thus encouraging further corruption and nepotism." (novaekonomija.rs/arhiva-izdanja/broj-48-mart-2018/hronične-bolesti-srpskog-zdravstva). We should expect the corona virus epidemic to increase the number of healthcare workers, a conclusion rendered based on information provided in the media. The president of the Serbian Trade Union of Doctors and Pharmacists, Rade Panić, announced that "under normal conditions, there is a shortage of approximately 2,500 physicians and 8,000 medical technicians".

Healthcare restrictions impact those most vulnerable, the poor and the marginalised. In a survey conducted by the Centre for Democracy Foundation in July 2020, the small number of managing directors of healthcare centres that agreed to participate in the survey indicated the following consequences of the employment ban: (1) reduced numbers of medical personnel due to the ban on the automatic replacement of employees who have retired or terminated their employment relationship for some other reason; (2) reduced scope of work and/or termination of certain services (mobile teams, house calls, emergency services, closure of rural clinics, etc.); (3) overworked employees and increased workloads; (4) additional administration; (5) additional funding of healthcare centres from municipal funds. The managing directors of healthcare centres have confirmed the justification and importance of using mobile healthcare teams that provide services to the residents of rural communities on a daily basis.

Recommendations:

A key recommendation is the necessity to **reduce the number of inhabitants per physician** especially in **municipalities where this ratio is significantly above the Serbian average.** These are, as a rule, municipalities with a larger share of inhabitants who live in rural communitities, as well as municipalities/towns that do not have specialised healthcare insitutions (clinical centres, hospitals, etc.). It is necessary to determine minimium standards in this relation and to secure measures for their implementation. Including the private sector in the healthcare protection system would surely assist in the achievement of this objective.

Given that the number of inhabitants in rural communities is constantly declining, the most reliable mechanism are **mobile services** (consumer-oriented services), which has become a tradition in many social and cultural areas within democratic systems that are based on the rule of law. The point of mobile services is to periodically (once/twice per week) or as needed (per call) visit the user in his/her place of residence. Mobile services which include a vehicle that has been fitted with the required equipment (lab, dentists office, mammograph, etc.) and a corresponding team (physician, medical lab technician, etc.) who periodically or per call, visit the community and work either in the vehicle or in a facility located in the community (clinic, home assistance, etc.). Mobile services increase the quality and availability in areas where inhabitants have access to sub-standard levels of stationary services. Considering that mobile programmes are not economically lucrative, it is understood that they require various forms of subsidising. Intersectoral connection of mobile services in rural communities may reduce costs. Permanent and ad hoc combined teams can be formed to provide services for a specific community (personal assistant, physician, nurse, geronto housekeeper, a teacher who teaches special subjects in primary school, and others) with the right equipment in the vehicle. Mobile programmes have a high level of flexibility and are easily adaptable to the demographic features of the population and needs of the local community.

There is no reason to further postpone the inclusion of the private sector as a provider of public healthcare services. This would, on the one hand, expand healthcare services on offer, and thereby encourage competition and improve the quality of the healthcare services on offer. On the other hand, the financial flows within this sector would be more transparent. Including the private sector could be an incentive to strengthen the position of GPs who perform house calls, as well as neighbourhood physicians.

Of particular importance to improving healthcare services in rural areas is to ensure **connection and joint programmes at the municipal level to be provided to several communities, as well as at the inter-municipal level**, which may include only sectoral programmes or cross-sectoral connections. Such forms of connection and appropriate programmes should be accompanied by adapted forms of connecting isolated rural communities with the municipal centre or neighbouring municipality (subsidised licensed taxi transport, use of off-road vehicles, etc.).

To oblige actors in the healthcare services sector to apply **the spatial accessability dimension** and mechanisms which aim to allow citizens to exercise their healthcare protection rights in strategies, action plans and other documents.

Adopt a law on **non-profit professional organisations** with special provisions and norms that apply to organisations **trained and accredited to work in rural communities.**

Ksenija Petovar
Professior (retired) at the Faculty of Architecture and Geography at the
University of Belgrade
Member of the Board of Directors of the Center for Democracy Foundation